Gynecology Health History

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: ____________________

Address: ____________________

____

Home Telephone No: ( ) ____________________

Work Telephone No: ( ) ____________________

Reason for Visit: ____________________

Date of Birth ____/____/____ Age: ____ Religion: ____

Marital Status: ☐ S ☐ M ☐ D ☐ SEP ☐ W Race: ____

Education: ____ Years Occupation: ____

Employer: ____________________

Type of Insurance: ____ Policy#: ____

Referring Physician: ____________________

Primary Physician: ____________________

1. CURRENT MEDICATIONS ☐ None

____

____

____

2. MEDICATION ALLERGY / SENSITIVITY ☐ None

List all medications allergic to:

____

____

____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term= 40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	Complications No
1	/		lbs. oz.					☐	☐
2	/		lbs. oz.					☐	☐
3	/		lbs. oz.					☐	☐
4	/		lbs. oz.					☐	☐
5	/		lbs. oz.					☐	☐

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:

		You	Your Family
3.	High Cholesterol	☐	☐
4.	Heart Disease	☐	☐
5.	Rheumatic Fever	☐	
6.	High Blood Pressure	☐	☐
7.	Asthma	☐	
8.	Tuberculosis	☐	
9.	Diabetes	☐	☐
10.	Thyroid Problems	☐	☐
11.	Liver Disease	☐	
12.	Stomach, Bowel or Gall Bladder Problems	☐	
13.	Kidney or Bladder Problems	☐	
14.	AIDS (HIV)	☐	☐
15.	Hepatitis (type____)	☐	☐
16.	Anemia or Blood Disorder	☐	☐
17.	Blood Transfusion	☐	
18.	Allergies	☐	
19.	Breast Problems	☐	☐
20.	Cancer	☐	☐
21.	Infertility	☐	
22.	Female or Sexual Problems	☐	
23.	Chlamydia	☐	
24.	Gonorrhea	☐	
25.	Herpes (HSV)	☐	
26.	Syphilis	☐	
27.	Birth Defects or Inherited Diseases	☐	☐
28.	Sexual Abuse or Domestic Violence	☐	☐
29.	Other Medical Problems	☐	☐
30.	**No Known Medical Problems**	☐	☐

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____/____/____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ☐ Excessive Bleeding ☐ Discharge ☐ Pain ☐ None

39. CONTRACEPTIVE HISTORY

Type	Dates Used
Oral Contraceptive	☐ ____
Type(s)____	☐ ____
____	☐ ____
IUD	☐ ____
Diaphragm	☐ ____
Norplant	☐ ____
Sponge	☐ ____
Spermicide	☐ ____
Condoms	☐ ____
Other ____	☐ ____

Sterilization ☐ Male ☐ Female

LIFESTYLE

		Yes	No
40.	Did your mother take DES or any other hormones when pregnant with you?	☐	☐
41.	Have you ever had a Pap test?	☐	☐
	If Yes: Date of your last Pap test? ____/____/____		
	Have you ever had abnormal Pap test results?	☐	☐
42.	Are you sexually active?	☐	☐
43.	Do you have one partner or many partners	☐ one	☐ many
44.	Is intercourse painful for you?	☐	☐
45.	Do you do a monthly self breast exam?	☐	☐
46.	Have you ever had a mammogram?	☐	☐
	If Yes: Date of your last mammogram? ____/____/____		
47.	Do you exercise on a regular basis?	☐	☐
	If Yes: Type of exercise ____		
	Hours per week exercise ____		

SIGNATURE: ____________________ **DATE** ____________________

31. HOSPITALIZATIONS List operations/serious illnesses that have required hospitalization. If more than six, check this box. ☐ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	Complications No
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐
/		☐	☐

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ☐
Type ____
Amt/day ____

33. Tobacco ☐
Type ____
Amt/day ____

34. Caffeine ☐
Type ____
Amt/day ____

35. Non-Prescribed Drugs ☐
Type ____
Amt/day ____
Type ____
Amt/day ____

36. Street Drugs ☐
Type ____
Amt/day ____
Type ____
Amt/day ____

PHYSICIAN NOTES: